Crater Local Human Rights Committee Meeting
Thursday, April 11, 2013
5:30 PM

Committee Members Present:
Mr. Edward Barlow, Chair
Ms. Jean Grim, Vice Chair
Mr. Carlton Starke
Ms. Mary Wallace
Mr. Steve Pories
Mr. Daniel Moore
Ms. Sequoya Willis (Absent)

Human Rights Advocate
Taneika Goldman
Carrie Flowers, Human Rights Advocate

Crater LHRC Secretary
Ms. Fabri D. Claiborne

Affiliates Present:

Adult Activity Services – James Scott
Benchmark Residential Services – Clarence Dilworth
Dan-Poe-Dil, Inc. – Clarence Dilworth
Happy Home Counseling Services – Quinn Wilson
JC HomeLife – Keith Blom, Rodarneek Om
Low Ground Visions, Inc./Day Support –Chanda Batts Stevenson
New Beginning, Inc. – Marilyn Newby, Patricia Tucker
Phoenix and Peace – Marilyn Newby, Patricia Tucker
Progressive Adult Rehabilitation Center, Inc. – Felecia Daniels
Pryor House – Jeronica Page
Southside Regional Hospital – Inpatient, Outpatient – Sandra McCabe
TruCare Homes, LLC – Simone Harris
DePaul Community Resources – Peggy Ball
John Randolph Medical Center
Live 4 Life, Inc. – Jason Jackson
Visions Family Services, Inc. –Michael Nichols

Affiliates Absent:

Family and Youth Services

I. Call to Order

A quorum being present, Chair Edward Barlow called the Crater Local Human Rights Committee meeting to order at 5:32 PM at Taylor-Starkewood Enterprises 589 S. Crater Road, Petersburg, Virginia.

I. ***Public Comments:***

None

II. Approval of Minutes

A motion was made and seconded to approve the minutes of the Thursday, January 10, 2013 meeting. Ayes: Carlton Starke, Daniel Moore

III. Advocate's Comments

Carrie Flowers presented Ms. Mary Wallace with an appreciation plaque. Ms. Wallace has decided to resign from her duties as a Crater LHRC Committee Member. Taneika Goldman introduced herself. Ms. Goldman is the new Human Rights Advocate for Crater LHRC. She passed labels out for the affiliates to update their posters.

IV. Financial Report

Mrs. Newby informed affiliates of the ending balance for the Crater LHRC. She informed affiliates that she will need to meet with them in lieu of the Crater LHRC meeting to discuss affiliate dues.

V. Old Business

Mr. Barlow informed the affiliates that all annual reports should have been submitted at this time. Annual reports will be reviewed during the next meeting.

VI. New Business

Providers are no longer to send reports to Yolanda Smith. Ms. Smith will soon be leaving. The community complaints report will now be sent to the Human Rights Advocate, Taneika Goldman.

A new system is expected to be implemented by July entitled CHRIS. The acronym CHRIS stands for Computerized Human Rights Information System. The webinar training information on CHRIS was submitted to affiliates from Dr. Margaret Walsh, Director of Human Rights and emailed from Fabri Claiborne, Crater LHRC Secretary.

Once your agency is notified about CHRIS training, make sure all individuals who submit reports receive the training.

The trainings are being conducted in phases:
Phase 1: Community Service Boards
Phase 2: Providers of ID services
Phase 3: Community based providers

VII. Event Report Statistics

Reports from each provider on events occurring during the reporting period of January 1, 2013 – March 31, 2013

a) **Adult Activity Services** -
On March 4, 2013 a female client fell to the floor in the Day Support training area. The fall caused re- injury to an existing would near right eye. First aid was administered immediately.

On March 14, 2013 a female client was brought to Day Support by District 19 unresponsive in a wheelchair. When asked, D19 explained the client had not slept in two days. Staff members would wake the client periodically.

Ms. Flowers explained that the information reported was not necessarily a serious incident to report.

b) **Benchmark Residential Services**
Carson House
No Activity to report.

c) **Dan-Poe-Dil**
Wedgewood House
No activity to report

Church Road House
On March 29, 2013, the mother of a client residing at the Church Road House contacted the Program Director stating that her son was having pains in his groin area. This information was given to her from the supervisor of another day support program her son attended. After being examined by the nurse, it was noted his testicles were bruised and swollen. Upon being asked the client stated he fell on a chair. When taken the emergency room, the physician noted there was no bruising, swelling, or sign of trauma. There was no physical evidence found. Interviews were conducted. In conclusion there was no evidence of abuse or neglect.

Fairway House
On March 5, 2013 an individual residing at the Fairway House attacked a staff member, causing injury to their right eye. The program director was contacted. The residential counselors and the client were interviewed. It is noted that the client has a history of physical aggression. The client admitted and apologized for the assault. He stated he was upset because his mother was unable to visit and he does not like people to tell him what to do.

d) **DePa ul Community Resources**
No incidents to report.

e) Family and Youth Services
Absent. No Report Submitted.

Mr. Barlow stated it is the committee's recommendation for citation for non-attendance and noncompliant report submission.

f) Happy Home Counseling
No activity to report.

g) **High Hopes**
Site has been closed.

h) JC Homelife
No activity to report.

i) **John Randolph Medical Center** –
No report submitted. Changes have occurred in their department. There is a new liaison that is unfamiliar with the LHRC process. Stated the reports were submitted to the Office of Human Rights, but not to Crater LHRC Secretary. The liaison was informed to get with Ms. Claiborne to ensure he received the necessary dates and she had his contact information.

j) Lea and Associates
Intensive In Home
No activity to report

k) **Live 4 Life** –
No activity to report

l) **Low Ground Visions, Inc**.

Residential Service

A client was taken to the emergency room which later resulted in hospitalization on several occasions from 1/6/2013, 2/11/2013, 3/1/2013,3/8/2013. On March 28, 2013 the client was transferred to Emporia Manor Nursing Home. On March 30, 2013 the client died at Southside Regional Medical Center.

On March 10, 2013 another client was taken to the emergency room for fracturing left foot after a seizure. The same client was taken back the emergency room that day for a swollen lip.

Day Support

No activity to report.

m) New Beginning, Inc.

Day Support

No activity or changes to report.

Residential

A client was left unsupervised on the transportation van. The necessary individuals were contacted on February 20, 2013. An investigation was conducted. The investigation found that the DSP did not check the van to ensure that all individuals had not exited the van. The staff member resigned on February 20, 2013. The following actions will now be taken to ensure no one left behind.

Update to, "Accountability Guidelines", ("DSPs escorting Individuals on various transportation will take a head count at the beginning and end of the trip. Additionally, DSPs will check each seat of the transportation to ensure no one is left behind.)

"Transportation Checklist", (Post-Trip Inspection: Ensure no one is left on transportation and all belongings are removed.)

Disciplinary action

Individuals going on appointments will remain in their homes and depart for appointments from there or will be picked up for the appointment from their Day Support Program.

INCIDENT #2

On March 5, 2013, a client awakened at 5:30 AM and was unable to walk. The necessary individuals were contacted on March 5, 2013.

3/5/2013, DSPs on duty at New Beginning I Residential were [redacted] and [redacted]. At 5:30 AM, [redacted] entered the bedroom to awaken Mr. Rogers for his morning routine. Realizing, he was awake but uncharacteristically, not getting out of the bed, DSP pulled back the bedding and noticed that he was reluctant to roll over. He exhibited no signs of distress or discomfort and the attempt to help him to his feet, was unsuccessful. Program Director contacted regarding the situation. Emergency Rescue was called.

[redacted] examined him for injury. No bruises were noted. A scratch was noted on his left knee and also on his forehead. The Emergency Rescue Staff conducted a body check and took vital signs; noting blood pressure, pulse and heart rate to be good. The Emergency Rescue Staff stated to Program Director that no distress or discomfort was noted during his examination of [redacted] legs or pelvis region.

DSPs reported that rounds were made throughout the night. Additionally, he characteristically does not awaken to use the restroom throughout the night. This was supported by his indicating his need to urinate; he was assisted to a portable potty.

His Physician's office was contacted and he was transported to the Physician's office. He was examined by his Physician and orders provided for evaluation in the ER Dept. for: pain in left leg, inability to use left leg, fever. He was diagnosed with a broken hip. The individual is diagnosed with Scoliosis. He receives medications of the treatment of Seizure Disorder, Hypertension, Adjustment Disorder, Constipation, Cholesterol (high), Psychosis NOS, Bladder Incontinence.

n) Phoenix-N-Peace, Inc.

Residential

Around 9:30 a.m. January 26, 2013 it was brought to the attention of the Program Director by a DSP that an Individual had cut herself on the abdomen area and it appeared she needed medical attention. Emergency Personnel (911) was called for support and the on-call supervisors for the weekend were notified. The Program Director for the house also went to the residence. Upon her arrival, Petersburg EMT and Police were at the home. While the EMT's were with the Individual the Police requested background information on the Individual and this was provided. The Police informed one of the weekend supervisors that the Individual would be transported to Southside Regional Medical Center and they would be referring her to District 19 for a crisis consultation. The QAD could not be reached but the Executive Director was contacted. The Program Director also accompanied the Individual to the hospital. Once there she was able to reach the QAD who was updated along with the Executive Director. The Program Director also spoke with the District 19 Crisis Staff who was also given the Individual's background information. While in the Emergency Room the Individual would not have conversation with the staff but talked to the Police Sgt. who

was assigned to watch her. She continued to refuse to speak with staff although attempts were made. When the Doctor told her he would be stitching her wound area. The Individual informed the doctor that the numbing medication was not going to work and that she may need something stronger. He replied what he was giving her would numb the area. Once the stitching was completed the Individual questioned staff if she would be given any more medication, stating "she wanted something for her agitation but would only take was a PRN". Staff was told once she was moved to the Psych/Behavior floor the doctor would be called for further instruction. Later when a DSP came on duty, she reported to the hospital and went to where the Individual was. She was willing to talk to staff. The Program Director questioned the Individual and asked why she inflicted the wound on herself. She

stated she was upset because she could not talk to her people at Eastern State. The Program Director reminded her she had talked to her family and she was going to make arrangements on Monday for her to talk to her Support Coordinator at Eastern Shore. The Individual told the Program Director that, that evening after they returned home she and staff was sitting in the living room watching television and she got up and went in the kitchen to put her bottled water in the refrigerator. That is when she got a knife from the kitchen drawer and hid it under her clothing. Staff remained at the hospital with the Individual until her TDO orders came in. The orders were read to her by the Police Sgt. Afterwards a hospital attendant escorted her to the 2nd floor. She was admitted at 2:30 a.m. The on-call supervisor was notified. The Individual was discharged on January 31, 2013.

This investigation concludes that staff failed to provide the close supervision as required. After finding the Individual with the knife staff made the decision to put herself in harm's way and remove the knife from the Individual even after the Individual during the time of the incident, was at first unwilling to give staff the knife when asked. The home itself failed to place all objects of potential harm away under lock and key. Therefore neglect was founded.

Due to the Individual's mental health status and her background history of self injury the home was given a full and complete visual make over. Staff was retrained on the potential dangers of objects in the home that the Individual can use to harm herself. All rooms in the home were checked for potential objects that the Individual could harm herself with. In the kitchen all knives and the silverware are now kept under lock and key. In the bathroom all drawers/cabinets were checked for potential objects of self-harm. In her bedroom all areas were checked. Her personal care items on the dresser are under lock and key as well as cleaning out her purse for potential dangerous objects. The Individual will have access to all of the items however staff will unlock the compartment that the items are kept in, hand them to her an watch her closely when she dispenses her lotions, body wash, creams, etc. Staff will provide close visual supervision to her at all times which will include while she is in the bathroom, taking her shower, in bed, cooking, drawing, writing and monitor the programs she watches on television since some shows are trigger points for some of her behaviors. During the night staff will sit in the room with her to provide visual contact. All pens and pencils will be locked and when she wants to draw or write in her journal, staff will unlock these items and sit with her while she is drawing/writing and she has completed the activity she will give the items back to staff to be locked up. Staff supervision was also increased. Since the DSP who was with the Individual at the time of the incident is new and has less experience she has been transferred to one of the day support locations where she can enhance her skills and be involved with more individuals. The Individual does not attend this day support. A more seasoned staff has been assigned to work with the Individual in a 2:1 capacity.

At 7:41 p.m. on February 21, 2013 the Individual displayed combative behaviors and self harm to self and others. The reason was not clear as she would not state what upset her. Prior to the incident the Individual and staff were in the kitchen

talking about completing her job resume, as she wants to get a job. She then became upset because she does not want to be awakened to go to day support. She had been out for two days, as she refused to go. She was asked if she wanted to talk to START but she did not get anyone. The Supervisor finally was able to get someone at START but the Individual did not want to talk to the male on call. She insisted on talking to her regular counselor. She remained upset and agitated and continued to attempt to do bodily harm to herself and others. This escalated to the staff calling 911 for support. When Police arrived she tried to grab her eyeglass case so she could get to the glasses to stab herself. Because she was not successful she became even more agitated and fought the Police and staff. Police cuffed her and took her to Southside Regional Medical Center for evaluation. At the hospital she was evaluated by District 19 Crisis Staff. The results of that evaluation deemed her safe to return to the residential home. She was discharged and she returned to the residence.

At 10:00 p.m. on February 22, 2013 the Individual reopened the wound on her stomach area. Individual was being counseled by her START staff counselor. She was being questioned on her behavior the previous day. The Individual shut the door appearing not wanting to discuss it. She went to her room and staff went with her. She slept for about two hours while staff sat with her. The START counselor stated individual stated she could open the old wound with her hands. Upon hearing this staff provided visual support watching her hands. At about 8:50 p.m. the Individual and staff were in the living room watching TV. At 9:20 p.m. they were still watching TV. At 10:00 p.m. the Individual appeared to be getting restless. She put her hand underneath the blanket. Staff continued to watch her and later asked her to remove her hands from underneath the blanket. She yelled NO and refused to let staff see what she was doing. Reportedly the Individual stated if she showed them what she was doing she would be removed from the home and she did not want that. The Supervisor was called and updated on what was going on. She advised them to offer her a PRN and contact the START person on call which the staff did. The Individual accepted the PRN and the START team came over. District 19 Crisis staff called and advised Emergency Room treatment for the reopened wound area. After 911 EMT's arrived, the Individual stated to staff that she put her finger in naval area and with other hand pulled on her stomach area hard enough to pull the old wound open. She continued to do that until she reached the tender spots where she could feel pain then she stopped. Upon arrival at the Emergency Room the Physician did a brief psychiatric evaluation and determined further evaluation to be done and she was admitted to the psychiatric floor. Wound area was treated, no stitches just cleaned and packed.

At approximately 6:00 a.m. on 3/11/13 the on call supervisor received a called from the Supervisor of the residence that an Individual had reopened a wound with some scissors as reported by the staff on duty. The staff informed the on call supervisor that the Individual had stated that she had gotten scissors at approximately 9:50 p.m. on 3/10/13. The on call supervisor was unable to reach the QAD but did reach the Executive Director at 6:05 a.m. When the DSP on duty was questioned she stated the Individual was sitting on the side of

the bed and she asked her if anything was wrong. She noticed the blood and scissors and that is when the Individual informed her she got the scissors at 9:50 p.m. The DSP also informed the on call supervisor that it appears that the blood had stopped and it was like a blood from a pin stick. After first refusing, the Individual allowed the DSP to clean the wound. The area was cleaned three times. The Individual refused to allow staff to take her to the hospital. The individual went through her morning routine including packing her lunch for Day Support. When she got in the vehicle she was taken to Southside Regional Medical Center Emergency Room. Initially the Individual informed staff she was not going to Southside Regional Medical Center. When she arrived at the hospital she did not refuse to go in. She directed staff to the correct entrance. Staff from the START program was contacted and arrived at the hospital. After that person spoke with the hospital Case Manager they decided that Crisis from District 19 needed to be contacted. After the District 19 Crisis worker spoke with the Individual she made a recommendation that a Psychological Evaluation be completed and it was determined that she be admitted for this. There were no vacancies at the local hospitals and it was not until approximately 10:30 p.m. that a bed was found at Southern Virginia Regional Medical Center in Emporia and she was transported there by the Petersburg Police.

The investigation concludes that the staff (Supervisor) on duty failed to provide the close supervision as required. The Executive Director spoke with that Supervisor and she indicated that her cell phone did ring and she remembered going to the living room to answer it because she had left it in there and the call was from a co-worker of the home. The Executive Director informed her that when she left to answer the phone and during that conversation is when the Individual indicated that she went into the closet because the keys were hanging in the door. The Supervisor admitted that when she finished the conversation and returned to the closet her keys were still in the door and the Individual was still in her room. The Supervisor stated she was talking to one of the workers of the house and they were discussing the Individual and she stayed in the living room to complete the conversation because the Individual gets so upset when she is the topic of discussion. The Executive Director informed the Supervisor that she failed to provide the constant supervision as required for the safety and welfare of the Individual, therefore neglect was founded.

The Supervisor had already submitted her retirement papers and the last day of her employment was scheduled for 3/15/13 but due to this incident she was released from this position on 3/13/13. The overnight staff was informed again that the Individual is to remain in physical view of the staff at all times and a staff meeting and training with all the staff at the home where the Individual resides was conducted to assure staff are suited for the home and are aware of the importance of the special supervision that the Individual requires to succeed in this placement.

Day Support

On February 15, 2013 approximately 9:35 a.m. staff noticed individual was missing from Day Support. Staff searched grounds but could not locate him. The QAD and Executive Director were notified and they joined the search and looked for individual

throughout the local community but could not locate him. Prior to disappearance no incidents were reported. He had asked to go to the Library but because he had been on two community outings that week, no more would be scheduled. He was informed a trip to the library would be scheduled for Tuesday of the next week. He agreed to this.

The individual had spoken with one of the supervisors at Day Support. After speaking with him he was instructed to go with his trainer, which he did. It is believed at this point instead of going to his area he continued out the rear door.

At approximately 11:15 a.m. the individual was returned to the center by the Chesterfield Police. Upon his return he was placed on one to one with no additional incidents. The individual has a trainer. Additionally he has two staff assigned to him when he is agitated or refusing to comply with rules and regulations. The trainer had been instructed on several occasions to remain in her area to support the individuals with supervision to prevent injuries, elopement and to support individuals with training. The trainer had been informed the individual is not on one to one but requires close supervision to prevent elopement.

The investigation revealed the trainer was negligent in supporting the individual with the necessary supervision required to prevent elopement. Therefore it is the recommendation of the supervisor that she receives a five day suspension. She is to be informed that she will be terminated if she does not comply with instructions and/or such as incident reoccur. The trainer has been given detailed instructions again regarding the individual's supervisor with the staff's role in supporting her and the individual. The supervisor will monitor the trainer's performance in this area and provide her guidance and instruction when needed.

At approximately 10:40 a.m. on February 11, 2013 the individual was participating in group discussion in activity room when she jumped up from her seat started to run forward and then collapsed on the floor. The Supervisor and two DSPs asked the individual questions but she gave no verbal response. 911 was called. Staff checked pulse and other vitals which were shared with EMTs. Individual was transported to John Randolph Medical Center and was later admitted to ICU. Individual was discharged on 2-15-13. Various test taken revealed no abnormalities.

o) **Progressive Adult Rehabilitation Center, Inc. (P.A.R.C.) –**

P.A.R.C Osage House

On January 31, 2013 a van driver was escorting individual from the van at the group home when individual tripped and fell on concrete sidewalk leading to the group home. Group home Counselor was standing in the door and reported that she witnessed the incident. Individual received an abrasion to the right side of the face and cut to the inside of the upper lip. Individual was immediately transported to John Randolph Medical Center for

evaluation. Individual received 5 stitches, ointment for the abrasion, a tetanus shot and a CT scan to rule out any head injuries. No other injuries were found. Case Manager, licensing specialist, authorized representative and Human Rights were notified. As a method to prevention future incidents of this nature, the provider developed an instructional Protocol for Transportation of individuals with fall risks.

On February 21, 2013, staff reported that individual appeared to have a seizure while sitting on toilet. Staff was in bathroom with individual and the seizure lasted for a few minutes. Staff took vital signs which appeared to be normal. The individual appeared to return to normal level of functioning; however, since this individual did not have a history of seizures, staff was instructed to contact the individual's' primary care physician. The primary care physician recommended that individual be taken to the emergency room for further evaluation. Individual was taken to John Randolph Medical Center where the individual was diagnosed with chronic bleeding on the brain and admitted to the hospital. Case Manager, licensing specialist, authorized representative, and Human Rights were all notified. Individual was treated and discharged back to Osage House on 2-25-2013.

On March 27, 2013 staff reported that they call 911 at 9:40 PM because individual was coughing and vomiting what appeared to be blood. EMS arrived and examined individual and vital signs appeared normal. EMS also examined vomit which EMS stated they did not think that it was blood. EMS did not transport and recommended that staff follow up with Primary Physician on 3- 28-13. Individual was transported to Primary Care Physician on 3 28 2013 at 9:30 AM. Primary Care examined and referred individual to John Randolph Medical Center emergency room. The emergency room physician could not determine any diagnosis so Primary Care Physician decided to admit the individual to hospital for observation, fluids, clear liquid diet, and follow up with additional test on 3-29-2013. Case Manager, licensing specialist, authorized representative, and Human Rights were notified. Individual was transferred from John Randolph Medical Center to Johnston Willis Hospital Neuro-Care Unit during the night. This is the same individual who experienced the seizure on 2-21-2013 and was hospitalized at John Randolph Medical Center.

An evaluation by Neuro-Surgeon at Johnston Willis Hospital revealed that individual has a lesion on the brain that caused the previous seizure, acute and chronic bleeding. Due to other health conditions of the individual, the Neuro-Surgeon did not recommend surgery. According the individual's

authorized representative, the Neuro-Surgeon stated he felt that the lesion would return and cause subsequent bleeding, if the individual was even able to survive the surgery. Individual's authorized representative concurs with the surgeon's recommendation not to perform surgery. Individual has been discharged by to Osage House.

P.A.R.C Day Support
No activity to report.

P.A.R.C Supported Living Services
No Activity or Changes to Report

p) **Pryor House**
On January 20, 2013 staff noticed that a client's face was swollen on the right side after waking from a nap. The program director was notified. The client was taken to the hospital. The doctor stated it was an abscess. The doctor lanced the abscess and prescribed antibiotics. A dental appointment was made for the client.

q) **Southside Regional Medical Center, Inpatient Services**
There were four incidents of restraints.

Mr. Barlow inquired about SRMC policy for restraints. Ms. McCabe stated she faxed a copy to both Mr. Barlow and Ms. Flowers.

r) **Southside Regional Medical Center Outpatient Services**
No activity or changes to report.

s) **T'LAB, Inc**.
No activity or changes to report.

t) TruCare Homes, LLC.
A client was taken to John Randolph Medical Center due to falling to his knees while closing the blinds. He then fell a second time falling to the floor and hitting the back of his head on the television stand. First aid was administered and blood pressure checked. The client received one suture to the head and was ordered to return in five days for it to be removed. The necessary individuals were contacted.

On February 14, 2013 police officers came to the home for one of the clients due to a neighbor alleging he trespassed on their property.

A client became agitated due to numerous calls from his mother. The client began making threats of knocking a window out and causing harm to his mother. The client later calmed down.

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u) Visions Family Services -

Intensive In Home

No activity or changes to report.

Residential

On March 11, 2013 it was brought to the reporter's attention that two individuals had what was believed to be consensual sexual intercourse on March 8, 2013. On that day the staff member was doing rounds and noticed the female client in the male client's bed. The staff member checked with a co worker to see if it was okay for her to be in his bed. The co worker stated it was inappropriate and needed to ensure they were monitored. On March 19, 2013 the female client was taken to the doctor for a pregnancy and STD testing. All came back negative.

The necessary individuals were notified and an investigation was conducted. Neglect was substantiated. VFS policy states that fifteen minute checks are suppose to be done throughout the shift.

Therapeutic Day Treatment

No Activity to Report.

VIII. Announcements / Updates (Chairperson's Closing Comments)

The next regular scheduled meeting will be held Thursday, July 11, 2013, 5:30 PM at Starkewood Counseling Services, 589 S. Crater Road, Petersburg, VA.
Thank you to Carlton Starke for providing the meeting location.

IX. Closed Session

A motion was made and passed at 7:15 PM that the Local Human Rights Committee go into Closed Session pursuant to the Virginia Code 2.2-3711-A.15 for the protection of the privacy of individuals, their records in personal matters not related to public business . Ayes Carlton Starke, Mary Wallace.

A motion was made to reconvene back to open session. Ayes Daniel Moore, Jean Grim.

X. Other Actions

None

XI. ***Adjournment***

There being no further business, the meeting was adjourned at 7:40 PM.

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Edward Barlow, Chair (Date)

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